MORRELL DERMATOLOGY, P.A.
PATIENT REGISTRATION

NAME OF PATIENT____ SEX: M / F
LAST FIRST MIDDLE INT.

ADDRESS____
STREET APT # CITY STATE ZIP CODE

HOME PHONE________________ CELL PHONE________________ WORK ________________

EMAIL ________________________ OKAY TO LEAVE MESSAGES ON: ________________

MARITAL STATUS S / M / D / W DATE OF BIRTH__________ AGE________ S/S# ____________

EMPLOYER____________________ RACE ______________

HOW DID YOU HEAR ABOUT US? ________________________________

EMERGENCY CONTACT (Nearest relative/person not living with you)

NAME________________________ RELATIONSHIP________________________

HOME PHONE________________ WORK PHONE________________ MOBILE PHONE________________

PLEASE ENTER INFORMATION ON THE PERSON RESPONSIBLE FOR THE BILL IF OTHER THAN THE PATIENT

NAME____________________ DOB______________ RELATIONSHIP________________

____
STREET APT # CITY STATE

PHONE________________________ SOCIAL SECURITY #________________________

__INSURANCE INFORMATION__

PRIMARY CARRIER (*Company)* ________________ SECONDARY CARRIER________________

INSURED NAME________________ INSURED NAME________________

SUBSCRIBER DOB________________ SUBSCRIBER DOB ________________

SUBSCRIBER I.D. NUMBER________________ POLICY NUMBER________________

GROUP NUMBER________________ GROUP NUMBER________________

YOUR RELATIONSHIP TO INSURED________________ YOUR RELATIONSHIP TO INSURED________________

__****PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST****__

FINANCIAL POLICY OF MORRELL DERMATOLOGY, P.A

Thank you for choosing MORRELL DERMATOLOGY, P.A. for your dermatology care. We look forward to serving your dermatology needs. We want you to be an informed participant in your healthcare. For your information, we have summarized our financial policy so you will know of our expectations regarding payment of your account.

If we have a contract with your insurance company, we will be happy to bill your insurance company after verification of your coverage, including eligibility, benefits and co-pay amount. All patients are required to bring their insurance cards with the policy ID number and phone number of insurance company. If you do not have your insurance card, you will be required to pay in full at the time of service. Patients are expected to pay in full any applicable co-payment, deductible and/or co-insurance at the time dermatology services are rendered in our office. **If we are unable to determine your financial responsibility at the time of service, payment is due in full when you receive your first statement.**

We will make every reasonable effort to collect payments that are due from your insurance company. However, you are ultimately responsible for timely payment of your account. We recommend that you follow up with your insurance company on any outstanding balance you might have with MORRELL DERMATOLOGY, P.A.

Laboratory tests, biopsies, or cultures obtained by the physician during your appointment, will be sent to an outside laboratory and **will not** be part of your office visit charge. You will receive a separate bill from the laboratory.

We accept Medicare assignment. If you do not have secondary insurance coverage, we are required by law to collect the 20% co-insurance of the Medicare allowable fee. We are also required to collect the annual Medicare deductible fee if you have not paid it prior to your appointment. Medicare only covers procedures that it deems are medically necessary. We will make every attempt to inform you if a requested procedure is or is not covered. However, you are responsible for payment in full of all non-covered visits and/or procedures at the time of service.

We are happy to offer the following payment options:

- We accept cash, MasterCard, Visa and Discover. **We do not accept checks**.
- CareCredit® (a GE Money Company): This is an attractive payment plan that allows you up to 6 months to pay, interest free
- **Please feel free to look at the CareCredit® brochures in the lobby or inquire at the receptionist desk regarding this payment option.**

I have read the above statement and fully understand my possible financial obligations.

______________________________ ________________________

Patient /Legal Guardian Signature Date

MORRELL DERMATOLOGY, P.A.
CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other people.

Procedure/Surgery appointments which are cancelled with less than 24 hours notification may be subject to a **$35 cancellation fee**.

Patients who do not show up for their appointment without a call to cancel will be considered a NO SHOW and may be subject to a **$35 no show fee**.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before or on the patient's next appointment.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department at 409-898-3900.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

____________________________________ Date of Birth: ______________

Patient Name (Please Print)

____________________________________ ________________________

Signature of Patient or Patient Representative Date

MORRELL DERMATOLOGY, P.A.
PATIENT AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

PATIENT NAME____
(Please Print)

AUTHORIZATION FOR TREATMENT: By virtue of my signature below, I authorize MORRELL DERMATOLOGY, P.A. and any of its employees or other authorized personnel or agents, to provide general healthcare service to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I hereby authorize MORRELL DERMATOLOGY, P.A. and any of its employees or other authorized personnel or agents, to release any of my medical records or other personal or medical information for purposes of determining benefits for services; for purposes of obtaining reimbursement from my insurance company of record, any public agency or any other potential third party payer. I also agree to allow MORRELL DERMATOLOGY, P.A. and any of its employees or other authorized personnel or agents to leave answering machine/voice mail messages and other forms of contact, including mail to my home or other designated location. I further authorize MORRELL DERMATOLOGY, P.A. and any of its employees or other authorized personnel or agents, including any laboratory of diagnostic testing facility performing services on my behalf, to release any of my medical records or other personal or medical information to any employee, authorized personnel or other agent of any physician, laboratory or diagnostic testing facility, or other healthcare provider involved in my care or treatment, for purposes of billing or obtaining reimbursement from any payer, or for the purpose of developing an appropriate treatment plan or diagnosis.

I acknowledge that MORRELL DERMATOLGOY, P.A. may use health information exchange systems to electronically transmit, receive and /or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

This authorization is intended to include disclosure of PHI by electronic means to the extent authorization is required by HIPPA and/or Texas Health and Safety Code Section 181.154.

I understand that photographs, video, and/or other images may be made/recorded for treatment and payment purposes only. I further authorize MORRELL DERMATOLOGY, P.A. to use any photographic images, which may be part of my medical records, for training purposes as indicated. I understand that such images will be adjusted as needed to eliminate identifying features (i.e., cropping so no full face images are identified, if applicable).

I acknowledge that the "Notice of Privacy Practices" provides information about how MORRELL DERMATOLOGY, P.A. and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations and otherwise as allowed by law. I understand MORRELL DERMATOLGOY, P.A. cannot be responsible for use or re-disclosure of information by third parties.

I authorize MORRELL DERMATOLOGY, P.A. to release any medical information pertaining to my medical care and treatment to my insurance companies necessary for the processing of my insurance claim. **SUCH RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THAT I HAVE OR MAY HAVE A COMMUNICABLE OR VENEREAL DISEASE, INCLUDING BUT NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS (ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME OR AIDS).**

I understand that this Authorization for Treatment/Release of Health Information will be valid and remain in effect as long as I attend or receive services from MORRELL DERMATOLOGY, P.A. unless revoked by me in writing with such written notice

Reviewed 6/2013

provided to MORRELL DERMATOLOGY, P.A. I do not have to sign this authorization in order to receive treatment Morrell Dermatology, P.A. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

3560 Delaware Suite 901
Address

Beaumont	TX	77706
City	State	Zip Code

Date______________________ **SIGNATURE**____

I acknowledge that I have viewed a copy of and /or been provided access to the **Notice of Privacy Practice** for MORRELL DERMATOLOGY, P.A.

Date______________________ **SIGNATURE**____

FOR MEDICARE PATIENTS ONLY

I request authorized **MEDIGAP** benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above **MEDIGAP** carrier any information needed to determine these benefits or the benefits payable for related services.

DATE______________________ **SIGNATURE**____

MORRELL DERMATOLOGY, P.A.

Patient Name: ______________________________ DOB: ______________________

HIPAA Privacy Act:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or have had the opportunity to read, if I chose) and understand the notice.

I acknowledge that the 'Notice of Privacy Practices' provides information about how MORRELL DERMATOLOGY, P.A. and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations and otherwise as allowed by law. I understand MORRELL DERMATOLOGY, P.A. cannot be responsible for use or re-disclosure of information by third parties.

As a patient of MORRELL DERMATOLOGY, P.A., I hereby give my consent to the physician and/or his/her staff to discuss my medical condition and any results from surgery, lab or x-rays or my billing account to the following people:

Name __________________________ Phone ___________________ Relationship __________________________

Name __________________________ Phone ___________________ Relationship __________________________

Name __________________________ Phone ___________________ Relationship __________________________

☐ I ELECT **NO DISCLOSURE** TO ANY PERSON. NO INFORMATION TO BE SHARED. ___________ (INITIAL)

Please print the telephone number, if any, where you wish to receive calls regarding your appointments, lab/test results and /or other health care information if other than your home phone number: (___) ________________

** Please be aware that a cell phone is **NOT** a secure and private line**

Can confidential messages (i.e. Appointment reminders and/or test results) be left on your telephone answering message or voicemail?

YES _____ NO _____

Patient Name ___________________________________

Patient / Guardian Signature: ____

Date: ___________________________

Morrell Dermatology, P.A.

PATIENT HISTORY

Please Print Clearly

Date________________________

Name ____ Age _______ Date of Birth ______________

Please state nature, location and duration of skin problem ____

Previous treatments: ____________________ Primary Care Physician: ________________________________

PERSONAL MEDICAL/SURGICAL HISTORY

Past Medical History: (please circle all that apply

Anxiety
Arthritis
Asthma
Atrial fibrillation (irreg. heart beat)
Bone Marrow Transplant
BPH (prostate)
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None

Other____

Past Surgical History: (please circle all that apply

Appendix Removed
Bladder Removed
Breast Biopsy
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colectomy: Colostomy
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
PTCA (angioplasty)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Nephrectomy (Removed) (Right, Left)
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP
Rectum: APR
Rectum: Low Anterior Resection
Basal Cell Cancer Surgery
Melanoma Surgery
Skin Biopsy
Squamous Cell Carcinoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer
None

Other____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Other ____

Do you tan in a tanning salon? Yes No Do you wear Sunscreen? Yes No SPF?__________

MEDICATIONS AND DOSAGE (PLEASE PRINT)

List present medications (including non-prescription and birth control pills):

1.______________________ 4.______________________ 7.______________________

2.______________________ 5.______________________ 8.______________________

3.______________________ 6.______________________ 9.______________________

ALLERGIES

Are you allergic to any medications? No Yes (if Yes, specify below)

Medication Reaction

1. ____
2. ____
3. ____

SOCIAL HISTORY

(Please circle all that apply)

Tobacco use Yes No If yes, Smokeless Tobacco or Cigarettes

Not sexually active

Sexually active with one partner

Sexually active with more than one partner

Drug use

IV Drug Use

Alcohol none

Alcohol less than 1 drink per day

Alcohol 1-2 drinks per day

Alcohol 3 or more drinks per day

FAMILY HISTORY: First degree relatives only (parents, siblings, children)

(Please circle all that apply and state relative below)

Melanoma Psoriasis Skin disease Malignant neoplasm of skin

Cancer Eczema Benign Neoplasm of skin Unknown

Other/Non Skin Related:____

Relative: ____

REVIEW OF SYSTEMS (Please circle all that apply)

Problems with bleeding

Problems with healing

Problems with scarring

Rash

Immunosuppression

Hay fever

Chest Pain

Fever or chills

Night sweats

Unintentional weight loss

Thyroid problems

Sore throat

Blurry vision

Abdominal Pain

Bloody stool

Bloody urine

Joint Aches

Muscle weakness

Neck Stiffness

Headaches

Seizures

Cough

Shortness of breath

Wheezing

Anxiety

Depression

Allergy to adhesive

Allergy to lidocaine

Allergy to topical antibiotic ointments

Artificial heart valve

Artificial joints within past two years

Blood thinners

MRSA

Pacemaker/ Defibrillator

Premedication prior to procedures

Rapid heartbeat with epinephrine

Pregnancy or planning a pregnancy

Other : ______________________

____

Is the reason you're here today causing any pain? Yes No

Pain Scale:	0	2	4	6	8	10
	No Pain	Little Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Pain